



REGIONAL CHIROPRACTIC CENTER

L A K E N O R M A N

736 Brawley School Road • Suite E • Mooresville, NC 28117
Office: 704-664-1031 • Fax: 704-664-1035 • www.regionalcc.com

PATIENT INFORMATION / HEALTH HISTORY

Name: _____ **Marital Status** (circle one): Single / Mar / Div / Sep / Wid
 DOB: _____ Age: _____ Sex: (circle one): Male / Female
 Nick Name: _____ Children's Names: _____ Spouse Name: _____
 Street Address: _____ City/State _____ Zip: _____
 Home Number: _____ Work Number: _____ Cell Number: & Provider: _____
 Social Security Number: _____ Occupation: _____ Employer: _____
 How did you hear about us? _____ Other family members seen here? _____
 Previous Chiropractic Physician: _____ Date of last visit: _____ Reason for care: _____
 Current Medical Physician: _____ Date of last visit: _____ Doctor Phone No. _____
Email Address _____ **Text reminders?** Yes / No: _____ **Cell Provider:** _____

HEALTH HISTORY

(PLEASE COMPLETE ALL SECTIONS)

Primary Complaint: _____ Secondary: _____ When did it start? #1 _____ #2 _____
 Suddenly Gradually Is this condition becoming worse? Y N Have you had this condition before? Y N
 How does this condition interfere with (circle all that applies): Work Sleep Daily Activities Driving Other: _____
 How severe is it on a scale 1-10 (1 being best and 10 being worst) How severe is it? _____ When did condition start? _____
 What caused the condition? _____ What makes it worse? _____ Better? _____
 Were other Doctors seen for this condition? Y N If yes, state who: _____ Results? _____
 Have you had **ANY** previous accidents (auto, motorcycle, sports, slip/fall) at home or work? (please include all dates) _____

 Have you ever been knocked unconscious? Y N Do you frequently experience dizziness or lightheadedness? Y N
 Have you had **ANY** broken bones or fractures? _____
 List ANY surgeries that you have had (Include dates if possible): _____

How would you characterize your health? Good Moderate Poor Do you have a pacemaker or defibrillator implant? Y N
 Do you use any of the following? (Please Circle) Tobacco Alcohol Caffeine Dairy Rate the stress in your life: Mild Moderate Extreme
 How often do you exercise? Never Occasionally Weekly Daily What type of exercise? _____

Please list Past Prescriptions: _____
 Please list Present Prescriptions: _____
 Over-The-Counter Medications: _____

VERIFICATION OF NON-PREGNANCY

I, _____, the Signature on this form, do hereby state that, to the best of my knowledge, I am not pregnant. It is neither suspected nor has been confirmed at this time.

[Type text]

[Type text]

[Type text]



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Please circle ANY of the following conditions that you have or have had in the past three months:

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE BELOW INFORMATION IS COMPLETE AND TRUE. IF MY MEDICAL/ HEALTH STATUS SHOULD CHANGE, I WILL INFORM MY PHYSICIAN AND/OR MASSAGE THERAPIST IMMEDIATELY.

Headaches	HIV/ AIDS	Stroke/Paralysis	Menstrual Pain
Stinging Head Pain	Chest Pain	Heart Attack	Menstrual Irregularity
Joint Pain	Incontinence	Low Blood Pressure	Diabetes
Loss of Smell	Blurred Vision	High Blood Pressure	Depression
Chronic Infections	Multiple Sclerosis	Rash/ Skin Conditions	Anxiety
Myofascial Pain	Tendonitis	Sprains/ Strains	Blood Clots
Chronic Fatigue Syndrome	Pregnancy	Tension/ Stress	TMJ/ Jaw Pain
Allergies	Light Sensitivity	Anemia	Irritability
Intermittent Fever	Shortness of Breath	Epilepsy/ Seizures	Indigestion
Muscle Spasm Low Back	Asthma	Varicose Veins	Cold Feet
Muscle Spasm Neck	Nervousness	Pins/Needles in Legs	Cold Hands
Loss of Taste	Shoulder Pain	Pins/Needles in Arms	Hernia
Inflammation of Throat	Swollen Ankles	Pins/Needles in Hands	Tonsillitis
Thyroid Trouble	Prostate Trouble	Numbness in Legs/Feet	TMJ Pain
Facial Twitching	Kidney Trouble	Numbness in Arm/Hands	Ulcers
Clumsy	Loss of Coordination	Mid Back Pain	Earache/ Ringing in Ears
Difficulty Sleeping	Cancer	Low Back Pain	Constipation
Dizziness/ Vertigo	Painful Joints	Neck Pain	Rheumatoid Arthritis
Stinging	Osteoarthritis	Hip Pain	MRI Referral
Loss of Balance	Swollen Joints	Facial Pain	Pacemaker

FINANCIAL INFORMATION

Who is responsible for this account? _____ Contact Number: _____

What method of payment will you be using? Insurance Cash Check Credit Card Other

SIGNATURE ON FILE

I authorize the use of this form on all insurance submissions.
 I authorize the release of information to all of my insurance companies
 I authorize that I am responsible for bill and/or balance
 I authorize payment direct to the treating doctor
 I permit a copy of this authorization to be used in place of the original

Date: _____
 Name (print): _____
 Signature: _____

Doctors Signature: _____

[Type text]

[Type text]

[Type text]